DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/16/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155291	B. WIN	G		11/21/2	U11
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	j		INDIAN	APOLIS, IN46214		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	-	CY MUST BE PERCEDED BY FULL  I SC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DE TELEVET ;		DATE
K0000	A Life Safety Co State Licensure State Licensure State Indiana State accordance with a Survey Date: 11.  Facility Number: Provider Number: AIM Number: 10.  Surveyor: Mark Code Specialist  At this Life Safel Valley Meadows compliance with Participation in N CFR Subpart 483.  Fire and the 2000 Fire Protection A Life Safety Code Existing Health C 410 IAC 16.2.  This one story factor of Type V (11 fully sprinklered alarm system with corridors and span The facility has a a census of 103 and span an	de Recertification and Survey was conducted by Department of Health in 42 CFR 483.70(a).  /21/11  000188 r: 155291 00266310  Caraher, Life Safety  ly Code survey, Eagle was found not in Requirements for Medicare/Medicaid, 42 8.70(a), Life Safety from Dedition of the National association (NFPA) 101, a (LSC), Chapter 19, Care Occupancies and cility was determined to 1) construction and was a The facility has a fire the smoke detection in the aces open to the corridors. In capacity of 115 and had at the time of this survey.		0000	The creation and submission this Plan of Correction does a constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Crec Allegation and requests a De review in lieu of a post survey review on or after 12/16/11.	not is et of lible sk	
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	3	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZMTQ21

Facility ID:

000188

If continuation sheet

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE ( A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/21/2011
		100291	B. WING	ADDRESS, CITY, STATE, ZIP CODE	11/21/2011
NAME OF P	ROVIDER OR SUPPLIER			VALLEY FARMS RD	
EAGLE V	ALLEY MEADOWS	}	INDIA	NAPOLIS, IN46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	The facility was with the aforeme requirements as a following:	·			
K0018 SS=E	than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door omeeting 19.3.6.3.6 Roller latches are regulations in all h Based on observations facility failed to a Rehabilitation Diprotecting corridorn impediment to This deficient pray	prohibited by CMS ealth care facilities. ation and interview, the	K0018	K 018 It is the practice of this provider to ensure doors protecting corridor openings other than required enclosure vertical openings, exits, or hazardous areas are substar doors, such as those construof 1 3/4 inch solid-bonded conveyed or capable of recisions	in es of nial ucted ore
	the Rehabilitation Findings include	n Dining Room.		wood or capable of resisting for at least 20 minutes. Door sprinklered buildings are only required to resist the passag smoke. There is no impedim to the closing of the doors.	rs in y e of nent

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155291		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  11/21/2011	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		_	DDRESS, CITY, STATE, ZIP CODE	
					LLEY FARMS RD	
	/ALLEY MEADOWS			INDIANA	APOLIS, IN46214	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	·		F		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Based on observ Maintenance Dir facility from 11: 11/21/11, the we Rehabilitation D the open position bottom of the do the time of obser Director acknow	rector during a tour of the 10 a.m. to 1:15 p.m. on est door to the ining Room was held in a with a door stop at the or. Based on interview at rvation, the Maintenance rledged the west door to ation Dining Room was	F	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ned of the coor dial ent
					Supervisor/designee will	
					complete the Life Safety Rev CQI weekly for four weeks,	iew
					monthly for three months and	
					quarterly thereafter. Safety	
					Committee to review audit re for compliance. If threshold	
					compliance. il un conola (	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION  01	(X3) DATE COMPL	
		155291	B. WINC			11/21/2	011
	ROVIDER OR SUPPLIER			3017 VA	DDRESS, CITY, STATE, ZIP CODE LLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
PREFIX	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  Based on observational facility failed to deserving hazardou kitchen latch into deficient practice resident, staff or the kitchen.  Findings include  Based on observational facility from 11:11/21/11, the kitchen	d construction (with ¾ hour ran approved automatic fire em in accordance with 8.4.1 beets hazardous areas. In other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches in the door are permitted.  Action and interview, the ensure 1 of 11 doors are as such as the other door frame. This is could affect any visitor in the vicinity of the door by the service			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	vill s fire oved eas aces and g and tted.	COMPLETION
	device and a post but the kitchen de the door frame be not completely co at the time of obs	ped with a self closing itive latching mechanism oor failed to latch into ecause the door would lose. Based on interview servation, the ector stated the door			affected by the deficient practice?  The kitchen door by the secorridor was corrected so the door would close and latch in the doorframe by the Maintenance Director on	ervice	
	ivialiticitatice Dil	color stated the door			11/22/11.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE COMPL		
		155291	A. BUII B. WIN	LDING		11/21/2	011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	{		3017 VA	ALLEY FARMS RD		
EAGLE \	ALLEY MEADOWS	3		INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		completely because the		TAG	How will you identify other		DATE
		evated and acknowledged			residents having the poten		
	the kitchen door by the service corridor				to be affected by the same		
		into the door frame.			deficient practice and what corrective action will be tal		
					·All residents who use the		
	3.1-19(b)				dining room have the potent	ial to	
					be affected by this deficient practice.		
					What measures will be put	into	
					place or what systemic		
					changes will you make to ensure that the deficient		
					practice does not recur?		
					·The Maintenance Directo	r and	
					or designee will monitor to e		
					that all doors can close mon How the corrective action(s)	-	
					be monitored to ensure the		
					deficient practice will not rec	ur,	
					i.e., what quality assurance program will be put into place	e? ·	
					The Maintenance Superviso		
					or designee will complete th		
					drill report monthly to ensure doors close. Data collected		
					be submitted to the CQI	*****	
					Committee for review and		
					follow-up If threshold of 90% not met a plan of correction		
					be completed.	*****	

000188

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291		LDING	01	(X3) DATE : COMPL 11/21/2	ETED
	PROVIDER OR SUPPLIER			3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0050 SS=F	varying conditions shift. The staff is is aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted betwee announcement manualible alarms. Based on record facility failed to conducted on the quarters. This deall occupants in tresidents, staff ar Findings include  Based on review Report" document Maintenance Dirreview from 9:20 11/21/11, there is available for review conducted on the quarter of 2011. The time of record Maintenance Dirwas conducted on the quarter 2011 was no document review of a fire dealers.	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, the document fire drills third shift for 1 of 4 efficient practice affects the facility including and visitors.  of "Monthly Fire Drill intation with the ector during record a.m. to 11:10 a.m. on s no documentation ew for a fire drill third shift for the third Based on interview at	K	0050	K 050 It is the practice of this provider to hold file drills that unexpected at times under varying conditions, at least quarterly on each shift. The is familiar with procedures at aware that drils are part of established routine.  Responsibility for planning at conducting drlls is assigned to competent persons who a qualified to exercise leaders! Where drills are conducted between 9pm and 6 am a connouncement may be used instead of audible alarms. We corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice?  A fire drill was conducted the Maintenance Supervisor the third shift on 12/13/11. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken All residents have the potents.	staff and is and conly are anip. ded hat by on	12/16/2011

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Event ID:

ZMTQ21 Facility ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED			
ANDILAN	or correction	155291	A. BUILDING	01	11/21/2011			
		155291	B. WING		11/21/2011			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  3017 VALLEY FARMS RD INDIANAPOLIS, IN46214					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-19(b)			to be affected by this deficier practice.  What measures will be put place or what systemic changes will you make to ensure that the deficient practice does not recur?  The Maintenance Director/designee will hold find drills quarterly on each shift.  The Fire drill - Shift/ Time Stagger schedule will be follow by the Maintenance Supervise How the corrective action(swill be monitored to ensure deficient practice will not reive, what quality assurance program will be put into plate. The Fire Drill - Shift/Time Stagger schedule will be review monthly by the Executive Dirand signed off for compliance Safety Committee to review the drill results monthly.	re  Dowed Sor. S) the ecur, see? sewed ector e			
K0062 SS=E	continuously mair condition and are periodically. 19 NFPA 25, 9.7.5 Based on observ facility failed to in the laundry ro of lint and dust of LSC 9.7.5 require systems shall be maintained in ac	ic sprinkler systems are itained in reliable operating inspected and tested in reliable operating inspected and tested in reliable operating inspected, the replace 5 of 5 sprinklers om which had a buildup on each sprinkler head. The all automatic sprinkler inspected, tested and cordance with NFPA 25, Inspection, Testing, and	K0062	K 062  It is the practice of this provious to ensure that the required automatic sprinkler systems continuously maintained in reliable operating condition a are inspected and tested periodically.  What corrective action(s) we	are			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155291	B. WING			11/21/2	011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ALLEY FARMS RD		
EAGLE \	/ALLEY MEADOW	S			APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Maintenance of	Water-Based Fire			be accomplished for those		
	Protection Syste	ems. NFPA 25, 1998			residents found to have be	en	
	edition, 2-2.1.1	requires any sprinkler			affected by the deficient practice?		
	shall be replaced	d which is painted,			practice:		
	_	ged, loaded, or in the			·The 5 sprinlker heads we	re	
	_	ation. This deficient			dusted and checked for dam		
		ffect residents, staff and			or corrosion by the Maintena	ance	
	•	·			Director on 11/22/11.		
	visitors in the vicinity of the laundry room.				Hammall (44/4 4)		
					How will you identify other residents having the poten		
					to be affected by the same	liai	
	Findings include	2.			deficient practice and what		
	Based on observation with the				corrective action will be tal		
	Maintenance Di	rector during a tour of the			·All residents have the pot	ential	
	facility from 11:	10 a.m. to 1:15 p.m. on			to be affected by this deficie	nt	
	11/21/11, all fiv	e automatic sprinklers in			practice.		
	· ·	n had a buildup of lint and			M/hat was a sure a suit ha mut	:4 a	
	1	inkler head. Based on			What measures will be put	into	
	_	time of observation, the			place or what systemic changes will you make to		
		rector acknowledged the			ensure that the deficient		
		_			practice does not recur?		
		rinkler heads had a			•		
		nd dust on each sprinkler			·The Maintenance		
	head.				Director/designee will compl		
					weekly and monthly checks		
	3.1-19(b)				the sprinkler system accordi preventative maintenance	ng	
					schedule.		
					How the corrective action(s	s)	
					will be monitored to ensure	-	
					deficient practice will not re	ecur,	
					i.e., what quality		
					assurance program will be	put	
					into place?		
					· The Executive Director	or will	
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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CON	ISTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	
		155291	B. WING	<u> </u>		11/21/2	011
	PROVIDER OR SUPPLIER			3017 VA	DDRESS, CITY, STATE, ZIP CODE  LLEY FARMS RD		
EAGLE V	ALLEY MEADOWS			INDIANA	APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					review the preventative maintance schedule with the Maintenance Director weekly four weeks and monthly thereafter.  Safety Committee to reaudit results for compliance. threshold of 90% not met a p of action to be completed.	eview If	
K0076 SS=E	are protected in ac Standards for Hea Standards for Hea (a) Oxygen storage 3,000 cu.ft. are enseparation.  (b) Locations for setthan 3,000 cu.ft. an NFPA 99 4.3.1.1.2 Based on observations facility failed to estorage locations cubic feet was set of a facility where examined, or treative barrier of 1 h construction. The could affect any other vicinity of the transfilling room.	e locations of greater than closed by a one-hour upply systems of greater re vented to the outside.  1, 19.3.2.4 ation and interview, the ensure 1 of 1 oxygen of greater than 3000 parated from any portion rein residents are housed, ated by a separation of a our fire resistive is deficient practice resident, staff or visitor in exoxygen storage and	K0	076	K 076 It is the practice of this provider to ensure that medic gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. Oxygen storage locations of greater than 3000 ft. are enclosed by a one hour spearation. Locations for supply systems of greater than 3000 cu. ft. are vented to the outside. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice?	cal on  0 cu. or an	12/16/2011
	Based on observa	ation with the			·The ceiling was removed in oxygen room and replaced w		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155291		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  11/21/2011	
	PROVIDER OR SUPPLIER		STREET A 3017 VA	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN46214	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	facility from 11: 11/21/11, the oxy transfilling room oxygen canisters room had one lay thick drywall. B time of observati Director acknow provide 1 hour fi	ector during a tour of the 10 a.m. to 1:15 p.m. on ygen storage and contained six liquid and the ceiling for the yer of five eighths inch ased on interview at the on, the Maintenance ledged the ceiling did not re resistive construction orage and transfilling		two layers of 5/8" thick fire-cdrywall by the Maintenance Director on 12/13/11.  How will you identify other residents having the potento be affected by the same deficient practice and what corrective action will be tall. All residents have the pot to be affected by this deficie practice.  What measures will be put place or what systemic changes will you make to ensure that the deficient practice does not recur?  The Maintenance Director/designee will monitor oxygen room for compliance. How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate. The Maintenance Supervisor/designee will complete the Life Safety Rec CQI weekly for four weeks, monthly for three months an quarterly thereafter. Safet Committee to review audit refor compliance. If threshold 90% not met an action plan be created.	tial  ken? ential int into  or the c. s) e the ecur, eace? view d y esults of

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155291	B. WIN			11/21/2	011
			B. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	5			APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	, -		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
K0143	Transferring of oxy						
SS=E		, 90					
00 L	(a) separated from	n any portion of a facility					
		are housed, examined, or					
		ration of a fire barrier of					
	1-hour fire-resistiv	e construction;					
	(b) in an area that	is machanically ventilated					
	<ul><li>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</li><li>(c) in an area posted with signs indicating that</li></ul>						
transferring is occurring, and that smoking in the immediate area is not permitted in							
	accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2						
		ation and interview, the	K0143	11/12	K 0143 It is the practice of this provider to ensure that the		12/16/2011
			IXC	1143			12/10/2011
		ensure 1 of 1 liquid		transferring of oxygen is (a)			
		reas where transferring of			separated from any portion o	f a	
		ce was separated from			facility wherein patients are		
		facility wherein residents			housed, examined or treated separation of a fire barrier of	-	
	•	nined, or treated by a			1-hour fire-resistive		
	separation of a fi	re barrier of 1 hour fire			construction;(b) in an area that is		
	resistive construc	ction. This deficient			mechanically ventilated,		
	practice could af	fect residents, staff and			sprinklered, and has ceramic		
	visitors in the vic	cinity of the oxygen			concrete flooring; and(c)in ar		
	storage and trans				area posted with signs indica	J	
	<i>5</i>	5			that transferrring is occurring that smoking in the immediat		
	Findings include				area is not permitted in		
	i mamga merade	•			accordance with NFPA 99 ar	nd	
	Based on observa	ation with the			the Compressed Gas		
		rector during a tour of the			Association. What corrective		
		•			action(s) will be accomplish		
	-	10 a.m. to 1:15 p.m. on			for those residents found to	,	
	11/21/11, the oxy	, ,			have been affected by the deficient practice?		
	transfilling room is posted with a sign				·The ceiling was removed i	n the	
	0 ,0	Transfer in Progress" and			oxygen room and replaced w		
	contained six liqu	uid oxygen canisters.			two layers of 5/8" thick fire-co		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPI 11/21/2	ETED
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD IAPOLIS, IN46214	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K0144	transfilling room five eighths inch interview at the t Maintenance Dir ceiling did not pr resistive construct storage and trans 3.1-19(b)	spected weekly and		drywall by the Maintenan Director on 12/13/11.  How will you identify or residents having the properties and corrective action will be affected by this depractice.  What measures will be place or what systemic changes will you make ensure that the deficie practice does not recurrent the Maintenance Director/designee will moxygen room for complication for complication practice will be monitored to endeficient practice will incomplete the Life Safety CQI weekly for four weekly for four weekly for compliance. If thres 90% not met an action be created.	other otential ame what we taken? e potential eficient  put into c t to nt r? nonitor the ance. ion(s) nsure the not recur, ance to place?  Il y Review eks, as and Safety dit results hold of	
SS=F	month in accordar 3.4.4.1. 1. Based on obsethe facility failed	ervation and interview,	K0144	K 076It is the practice of provider to ensure that are inspected weekly are exercised under load for	generators nd	12/16/2011
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	ZMTQ21 Facility	ID: 000188 If continu	ation sheet Pa	ge 12 of 18

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	LDING	NSTRUCTION  01	(X3) DATE COMPI 11/21/2	ETED
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
EAGLE VALLEY MEADOWS				ALLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		stop. NFPA 99, Health		minutes per month in accord with NFPA 99. What correct		
	Care Facilities, 3	•		action(s) will be accomplis		
	~	stalled as alternate power		for those residents found t		
		et the requirements of		have been affected by the		
	· ·	dard for Emergency		deficient practice?		
	1	Systems. NFPA 110,		·A remote shut off device	was	
		Level II installations shall		added to the emergency generator on 12/1/11 by Indi	ana	
	have a remote m	anual stop station of a		Power Service and Supply.	ana	
	type similar to a	break glass station		How will you identify other		
	located outside o	f the room where the		residents having the poten	tial	
	prime mover is le	ocated. NFPA 110, 7-1		to be affected by the same		
	states NFPA 37, Standard for the Installation and Use of Stationary			deficient practice and what		
				corrective action will be tall All residents have the pot		
		ines and Gas Turbines,		to be affected by this deficie		
		ory requirements for		practice.		
		rators and shall be		into		
	" " "	of the requirements of this				
		37, 8-2.2(c) requires		changes will you make to		
		rators of 100 horsepower		ensure that the deficient practice does not recur?		
		visions for shutting		·The Maintenance		
		•		Director/designee will compl	ete	
		at the engine and from a		the Emergency Generator		
		This deficient practice		Weekly Exercise/Monthly Lo	ad	
	l	esidents, staff and		test log weekly and monthly	2	
	visitors.			according to the preventative mainteance schedule.	<del>-</del>	
	B. 1			How the corrective action(s	s)	
	Findings include	· ·		will be monitored to ensure	-	
				deficient practice will not r		
	Based on observa			i.e., what quality assurance		
		ector during a tour of the		program will be put into pla		
		10 a.m. to 1:15 p.m. on		<ul> <li>The Executive Director will review the Emergency General</li> </ul>		
	11/21/11, a remo	te shut off device was		Weekly Exercise/Monthly Lo		
	not found for the	155 kW diesel fired		test log weekly for four week		
	emergency gener	ator. A sticker attached		monthly thereafter to ensure		
	to the nameplate	for the generator stated		compliance. · Safety Comr	nittee	

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CO	NSTRUCTION 01		(X3) DATE S COMPL	
AND FLAN OF CORRECTION		155291	A. BUII		01		11/21/2	
		100201	B. WIN				11/21/2	J 1 1
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STA			
EAGLE VALLEY MEADOWS					ALLEY FARMS R APOLIS, IN4621			
				<u> </u>	Al OLIS, 114021	<b>-</b>		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE AIDEFICIENCY)		PROPRIATE DA	
		service" was 01/07/81.			to review audit results for			
	Based on intervie			compliance. If thres			old of 90%	
		Maintenance Director			not met an action plan will be		;	
	acknowledged th				created.			
	_	off device for the						
	emergency gener							
	general gener							
	3.1-19(b)							
	>(0)							
	2 Based on reco	ord review and interview,						
		I to provide complete						
	documentation for							
		rators providing power to						
		ghting systems. LSC						
		A 99, Health Care						
		1.8 requires the generator						
		sufficient capacity to pick						
	` ′	neet the minimum						
	frequency and vo							
		the emergency system						
	•	ls after loss of normal						
		icient practice could						
	-	ts, staff and visitors.						
		,						
	Findings include	:						
	Based on review	of "Emergency						
		ly Exercise/Monthly						
		documentation with the						
	_	rector during record						
		a.m. to 11:10 a.m. on						
		ergency generator was						
	-	basis for at least thirty						
	_	onth for the period of						
FORM CMS-2	567(02-99) Previous Version	•	ZMTQ21	Facility l	ID: 000188	If continuation sh	neet Day	ge 14 of 18

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE COMPL 11/21/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP CODE	•	
EAGLE VALLEY MEADOWS					ALLEY FARMS RD APOLIS, IN46214		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	_	n 06/28/11 but the logs					
	1	cility did not record the					
	_	power from the main					
		mergency generator.					
		ew at the time of record					
		ntenance Director					
		ne transfer time to transfer					
	-	mergency generator was					
	of 01/11/11 thro	each month for the period					
		ugii 00/26/11.					
	3.1-19(b)						
		ord review and interview,					
	_	l to ensure a monthly load					
		nergency generators was					
		of 12 months using one of					
		ng methods: under rature conditions, at not					
		The Emergency Power					
		meplate rating, or loading					
		e minimum exhaust gas					
		recommended by the					
	_	Chapter 3-4.4.1.1 of NFPA					
		thly testing of generators					
	serving the emer	gency electrical system to					
	be in accordance	with NFPA 110.					
	Chapter 6-4.2 of	NFPA 110 requires					
		Level 1 and Level 2					
		ercised at least once					
		inimum of 30 minutes,					
	_	following methods:					
	_	ng temperature conditions					
	or at not less tha	n 30 percent of the EPS					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CO. LDING	NSTRUCTION 01	(X3) DATE COMPL	
		155291	B. WIN			11/21/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
EAGLE VALLEY MEADOWS					ALLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\IE	DATE
	nameplate rating						
		naintains the minimum					
	exhaust gas temp						
	_	the manufacturer.					
		e of day for required					
	_	ecided by the owner,					
		operations. NFPA 99,					
	_	a written record of					
		rmance, exercising					
	1 ^	rs shall be regularly available for inspection by					
		ring jurisdiction. This					
	deficient practice						
	residents, staff a						
	residents, starr ar	ilu visitois.					
	Findings include	:					
	Load Test Log" Maintenance Dir review from 9:20 11/21/11, month documentation w review for the per October 2011. E time of observation Director acknow documentation a	ly Exercise/Monthly documentation with the rector during record  a.m. to 11:10 a.m. on					
	2011. 3.1-19(b)						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	LDING	01	(X3) DATE COMPL 11/21/2	ETED
NAME OF	PROVIDER OR SUPPLIEF	<u> </u>		DDRESS, CITY, STATE, ZIP CODE	•	
EAGLE VALLEY MEADOWS				LLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the facility failed written record of the starting batter generator was moved. Chapter requires storage connection with systems shall be not more than 7 maintained in furth manufacturer's systems shall be immediately upon Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a written performance, excrepairs for the generator and visitors.  Findings include Based on review Generator-Week documentation wo Director during markets.	essential electrical inspected at intervals of days and shall be all compliance with pecifications. Defective repaired or replaced on discovery of defects. PA 110, 6-3.6 requires a batteries, including at intervals of not more apter 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and enerator to be regularly available by the authority on. This deficient fect all residents, staff				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
EAGLE VALLEY MEADOWS				/ALLEY FARMS RD NAPOLIS, IN46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	period in Februa week period from 10/31/11 was no Based on intervi review, the Mair acknowledged di battery inspection period in Februa week period from	ds for the four week ry 2011 and the twelve m 07/01/11 through t available for review. ew at the time of record ntenance Director ocumentation of weekly ns for the four week ry 2011 and the twelve m 07/01/11 through ot available for review.			